STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155072		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	X3) DATE SURVEY COMPLETED 08/27/2014	
	PROVIDER OR SUPPLIE		STREET A 2002 A	ADDRESS, CITY, STATE, ZIP CODE LBANY ST I GROVE, IN 46107	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES SICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F000000	State Licensure included a State Survey. Survey dates: A 22, 23, 25, 26, a Facility number Provider numbe AIM number: 1 Survey team: Karyn Homan, I Marsha Smith, I Dorothy Plumm (8/17, 8/18, 8/19, 8/25, and 8/26, 2 Patsy Allen, SW	: 000029 r: 155072 00275200 RN-TC RN er, RN 0, 8/20, 8/21, 8/22, 8/23, 2014) 7 0, 8/20, 8/21, 8/22, 8/23,	F000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

000029

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY OO COMPLETED			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00		
		155072	B. WING		08/27/2014	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE		
BEECH (GROVE MEADOWS	3		LBANY ST I GROVE, IN 46107		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE	
TAG	Total: 113	ESC IDENTIF TING INFORMATION)	IAG		DATE	
	10tai. 113					
	Residential samp	ole: 7				
	Thoso deficienci	es reflect state findings				
		ace with 410 IAC				
	16.2-3.1.	ice with 410 IAC				
	10.2 3.1.					
	Ouality review c	ompleted on September				
		nberly Perigo, RN.				
		, ,				
F000241	483.15(a) DIGNITY AND RESPECT OF					
SS=D						
	INDIVIDUALITY	romote care for residents				
	-	n an environment that				
	maintains or enha	nces each resident's				
		t in full recognition of his				
	or her individuality	•	F000241	1.Resident #67 was	09/26/2014	
	Based on observ	ation, record review, and	1000241	immediately assisted	09/20/2014	
		cility failed to ensure an		withpersonal care once		
	incontinent resid	•		incontinence was identified. 2.All residents have the		
		random observation of		potential to beaffected. All		
		ence. (Resident #67)		residents withincontinence we		
		(checked for needed assistance	e	
	Findings include	:		with personal care by DNS /Designee. Those requiring		
	_			assistancewere provided it		
	The clinical reco	rd of Resident #67 was		immediately.		
	reviewed on 8/21	1/14 at 1:30 p.m. Her		3.All staff will be in-serviced regarding residentdignity and		
	diagnoses includ	ed, but were not limited		incontinence management by	the	
	to, dementia and	urinary retention.		Staff Development Coordinate	or	
				/Designee. Resident Observa form willbe Completed on eac	II.	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITE	LDING	00	COMPLETED	
		155072	A. BUI B. WIN	LDING		08/27/2014	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		_
NAME OF P	ROVIDER OR SUPPLIER	t .			LBANY ST		
BEECH (GROVE MEADOWS				GROVE, IN 46107		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)		TAG		DATE	
	An annual Minir				shift by the DNS / Designee ar		
	assessment, date	d 6/16/14, indicated			be utilized to assurepersonal of needs are promptly	ale	
	Resident #67 was severely cognitively				addressed. Resident care plar	s	
	impaired, always incontinent, and needed				will be reviewed for accuracy a		
	extensive assista	nce of 2 or more staff to			resident profileswill be updated	d to	
	use the bathroon	1.			accurately reflect the residents	;	
	3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3				needs.		
	During a random	n observation, near the			4.Resident dignity and	ho	
	_	n 8/21/14 from 3:25 p.m.			incontinence managementwill monitored utilizing the	be	
		•			Accommodation of Needs CQ		
	-	sident #67 was observed			daily duringCustomer Care		
		lchair outside of her			Rounds by the Customer Care		
	-	fliquid was observed			Representatives or		
	directly under th	e seat of her wheelchair.			theirdesignee. Results of the		
	Various staff me	mbers walked past the			Accommodation of needs CQI		
	resident during t	hat time. Certified			be reviewed at Quality Assura meeting monthly for 6consecu	•	
	Nursing Assistar	nt (CNA) #4 was asked			months at 90% proficiency the		
	about the liquid	at 3:35 p.m. He			quarterly thereafter to		
	_	ced a white towel on top			2consecutive quarters. Issues		
		took Resident #67 into			identifiedwith Resident Dignity		
	_	the liquid on the floor			incontinence management will	be	
	soaked into the t				addressed by theQuality Assurance committee via		
		. At 3:40 p.m., the Unit			corrective action plan.		
		-			,		
	_	ed the resident had been					
		3:45 p.m., CNA #4					
	indicated the res						
		e sitting in the hallway in					
	her wheelchair.						
	On 8/22/14 at 11:45 a.m., the Director of						
	Nursing provided a policy dated 1/2006,						
	titled, "Resident Rights," and indicated						
	the policy was the one currently used by						
		policy indicated, "All					
	-	-					
	staff members re	ecognize the rights of					

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	AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155072		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 08/27/2014	
	ROVIDER OR SUPPLIER		2002 A	ADDRESS, CITY, STATE, ZIP CODE LBANY ST I GROVE, IN 46107	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
	assume their resp	mes and residents consibilities to enable well being, and proper"				
F000282 SS=E	CARE PLAN The services provide facility must be propersons in accordance written plan of care. Based on observer record review, the residents written followed for 7 of sliding scale insulas administered a physician (Resident #139), blood glu completed (Resident #600 completed as ord (Resident #11 and physician notification not completed (Figure 1) and physician for all movements (AIM).	ance with each resident's e. ation, interview, and the facility failed to ensure plans of care were figures and as ordered by the the sordered by the physician the sordered by the s	F000282	1.Licensed staff were immediately in-serviced ondocumenting the administr of sliding scale insulin for residents #70 and#139. Res #70 and #139 arereceiving sl scale insulin per physicians orders. Licensed staff were immediately in-servicedon completing and documenting blood glucose monitoring for residents #139, #26, and #67 Care plans were reviewed forresidents #139, #26, and # to ensure accuracy regarding diabetesmellitus. Residents #139, #26, and #67 are receiv blood glucose monitoring per physicians orders. Licensed were immediately in-serviced completing and documenting signs for residents #11 and #	ident iding 667 ving staff on vital	

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Facility ID: 000029

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DING	00	COMPLETED
		155072		LDING		08/27/2014
			B. WIN		ADDRESS SITU STATE TIP CODE	<u> </u>
NAME OF I	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP CODE	
		_			LBANY ST	
BEECH	GROVE MEADOWS	5		BEECH	1 GROVE, IN 46107	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
					Vital signs are being checked	per
	Findings include	·			physiciansorders for residents	5
	i mamgs merado	··			#11 and #69. Licensed staff w	/ere
	1 701 1 1 1	1 (D :1 : //50			immediately in-serviced on	
		record of Resident #70			reporting weight loss forreside	ent
	was reviewed on 8/19/14 at 5:15 p.m.				#123. Weights and physician	
	Diagnoses inclu	ded, but were not limited			notification are taking place	
	to, diabetes.				perphysicians orders for resident	ent
					#123. Licensed staff were immediatelyin-serviced on the	
	Resident #70 ha	d a plan of care dated			completion of AIMS for reside	l l
		•			#11, #70, and #139. Resident	
	1/1/12, indicating the resident was at risk				#11, #70, #139 had AIMS	
	for adverse effects of high or low blood				completedby DNS / Designee	on
	sugars related to	use of glucose lowering			9/2/14.	
	medication and/	or diagnosis of diabetes			2.All resident on Metoclopra	ım,
		entions included, but			requiringaccuchecks, requiring	g
		to, "blood sugars as			Weight Management, or recei	-
		•			Dialysis have thepotential to b	
	ordered and med	dications as ordered."			affected by this practice. Licer	
					staff were immediately in-serv	l l
	A review of the	recapitulation of			on documenting theadministra	
	physician's orde	rs for August 2014,			of sliding scale insulin by the S Development Coordinator	Stan
	indicated Reside	ent #70 was ordered			/Designee. An audit was	
		lovoLog, a short acting			completed by the DNS / Design	nee
		ling scale dose twice a			to ensure that residents with	
	· ·				sliding scale insulins	
	1 -	date of 7/15/12. The			werereceiving insulin as order	ed.
	_	se was based on the			Licensed staff were immediate	ely
	results of blood	glucose monitoring and			in-serviced oncompleting and	
	included blood g	glucose results of 200 -			documenting blood glucose	
	1	51 - 300 = 4 units, 301 -			monitoring. An audit was	
	350 = 6 units, $351 - 400 = 8$ units, greater than $400 = 10$ units, and call for blood				completed by the DNS /	
					Designeeto ensure that reside	l l
					with sliding scale insulins were receiving insulin asordered.	5
sugars less than 70 or greater than 500.				Licensed staff were immediate	alv	
					in-serviced staff were	-1y
	A review of the	Capillary Blood Glucose			immediatelyin-serviced on	
					completing and documenting	vital
	Monitoring Tool for July 2014, indicated Resident #70 was not administered				signs. An audit was complete	l l

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPL	ETED
		155072	A. BUII B. WIN	LDING		08/27/	2014
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R					
DEECH (GROVE MEADOW	6			LBANY ST I GROVE, IN 46107		
BEECH (3ROVE WEADOW	5		BEECH	1 GROVE, IN 40107		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	sliding scale ins	ulin as ordered.			by the DNS / Designeeto ensu		
					that residents vital signs were		
	On 7/3/14 at 6:0	00 a.m., a blood glucose			documented as ordered.	L.	
	of 230 was recorded. As indicated by the				Licensed staffwere immediate	•	
		•			in-serviced on reporting weigh loss. An Audit was completed		
	_	ler the resident should			the DNS / Designeeto ensure	-	
		units of NovoLog sliding			weight loss notifications are	٠	
	scale insulin. N	o sliding scale insulin			communicated with the		
	was documented	d as given.			attendingphysician. Licensed		
					staff wereimmediately in-servi	ced	
	On 7/4/14 at 6:0	00 a.m., a blood glucose			on the completion of AIMS for	•	
	of 308 was recorded. As indicated by the sliding scale order the resident should				residents receiving		
					themedications Metoclopram	and	
					Compazine. An audit was		
		units of NovoLog sliding			completed by the DNS / Design	gnee	
	scale insulin. N	o sliding scale insulin			to ensure that allresidents on medications requiring AIMS		
	was documented	d as given.			assessments were completed		
					3.Licensed staff will receive	•	
	On 7/8/14 at 6:0	00 a.m., a blood glucose			in-service trainingregarding		
		rded. As indicated by the			Diabetes Management via AS	С	
					policy, including completing		
	_	ler the resident should			accuchecksassessment post		
		units of NovoLog sliding			when appropriate, following th	ie	
	scale insulin. N	o sliding scale insulin			physicians orders, and		
	was documented	d as given.			theappropriate documentation		
					the Blood Glucose Monitoring		
	On 7/9/14 at 4·0	00 p.m., a blood glucose			Flow Sheet. Diabetes Management including followi	na	
		rded. As indicated by the			thephysicians orders and the	''9	
		•			appropriate documentation or	the	
	_	ler the resident should			Blood GlucoseMonitoring Flov		
		units of NovoLog sliding			Sheet will be monitored daily		
	scale insulin. N	o sliding scale insulin			audits of the MAR and		
	was documented	d as given.			FlowSheets by the Director of		
					Nursing / Designee. Licensed		
	On 7/11/14 at 4	:00 p.m., a blood glucose			staff will receive in-service		
		rded. As indicated by the			training regarding monitoring\	/ital	
		_			Signs including following the		
	_	ler the resident should			physicians orders and	uital	
	have received 8	units of NovoLog sliding			appropriatedocumentation of	vitai	

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	LDING	00	COMPLE	TED
		155072	A. BUII B. WIN			08/27/2	2014
		<u> </u>	D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			LBANY ST		
BEECH (GROVE MEADOW	S			I GROVE, IN 46107		
	T				1 010 12, 111 10107		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION DATE
TAG		· · · · · · · · · · · · · · · · · · ·		TAG	signs. VitalSigns Monitoring		DATE
		o sliding scale insulin			including following the physici	ans	
	was documented	d as given.			orders and the	ano	
					appropriatedocumentation wit	hin	
	On 7/12/14 at 6:00 a.m., a blood glucose				the MAR will be monitored da		
	of 271 was reco	rded. As indicated by the			via audits of the MAR byDirec	tor	
	sliding scale ord	ler the resident should			of Nursing / Designee.		
		units of NovoLog sliding			Licensedstaff will receive in-service training regarding		
		o sliding scale insulin			Weight Management including	athe	
	was documented	_			notification of physician for	,	
					significant weight loss per AS	С	
	On 7/12/14 at 4:00 p.m., a blood glucose of 320 was recorded. As indicated by the				policy. DNS / Designee will		
					conduct MAR audits toensure		
		·			weights are obtained and		
	_	ler the resident should			documented and to ensure physician is notified of any we	ight	
		units of NovoLog sliding			change per physicians	igni	
	scale insulin. N	o sliding scale insulin			order. Licensed staff will be		
	was documented	d as given.			provided in-service training		
					regarding the needfor AIMS o	n all	
	On 7/13/14 at 6:	:00 a.m., a blood glucose			residents taking Metoclopram		
		rded. As indicated by the			(Reglan), and Compazine, jus		
		ler the resident should			asthey would any anti-psycho medication. DNS / Designee v		
	_	units of NovoLog sliding			ensure that residents on	VIII	
		o sliding scale insulin			medications requiringmonitori	na	
					by AIMS assessment will be		
	was documented	a as given.			obtained by ASC policy of eve	ery 6	
					months. DNS/Designee will		
		:00 p.m., a blood glucose			ensure plans of care arefollow		
		rded. As indicated by the			regarding sliding scale insulin blood glucose monitoring, vita		
	sliding scale ord	ler the resident should			signstaken, notification of weight		
	have received 2	units of NovoLog sliding			loss, monitoring of involuntary	_	
	scale insulin. N	o sliding scale insulin			movements byreviewing the		
	was documented				facility activity report - which		
		5			report that monitorsdaily chart	ting	
	On 7/14/14 at 6	:00 a.m., a blood glucose			of significant events and by		
		rded. As indicated by the			conducting rounds each shift		
		•			dailyto ensure care plans are followed		
	sliding scale ord	ler the resident should			IOIIOWEG		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJI	DING	00	COMPLETED
		155072	B. WIN	LDING		08/27/2014
			b. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEF	8			LBANY ST	
BEECH (GROVE MEADOWS	5			I GROVE, IN 46107	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	have received 4	units of NovoLog sliding			4. Theresults of those audits	s will
	scale insulin. N	o sliding scale insulin			be compiled within the Blood Glucose MonitoringCQI month	alv.
	was documented	l as given.			at the Quality Assurance Mee	-
	On 7/16/14 at 6:00 a.m., a blood glucose of 236 was recorded. As indicated by the				for 6 consecutive months with	•
					95%proficiency then quarterly	
					thereafter for 2 consecutive	
		er the resident should			quarters. Vital Signs Monitori	•
	_	units of NovoLog sliding			including followingthe physicia	ans
		0 0			orders and the appropriate documentation within the MAF	,
		o sliding scale insulin			will bemonitored daily via audi	
	was documented as given.				of the MAR by Director of Nur	
					/ Designee. The results of the	
		00 a.m., a blood glucose			audits will be compiled month	-
	of 333 was reco	rded. As indicated by the			inclusion in the Quality Assura	
	sliding scale ord	er the resident should			Meeting for 6 consecutive mo	nths
	have received 6	units of NovoLog sliding			with95% proficiency then quarterly thereafter for 2	
	scale insulin. N	o sliding scale insulin			consecutive quarters. Weight	
	was documented	_			Management, including the	
		8			notificationof physician for	
	On 7/20/14 at 6:	00 a.m., a blood glucose			significant weight changes, wi	ll be
		rded. As indicated by the			monitored via the	
		er the resident should			ResidentWeights CQI monthly 6 consecutive months with 95	
	_				proficiency thenquarterly	70
		units of NovoLog sliding			thereafter for 2 consecutive	
		o sliding scale insulin			quarters. Completion of AIMS	S for
	was documented	as given.			appropriatemedications includ	
					Metoclopram and Compazine	WIII
		00 a.m., a blood glucose			be monitored by PsychoactiveManagement CC)
	of 243 was reco	rded. As indicated by the			tool monthly at Quality Assura	
	sliding scale ord	er the resident should			Committee meeting for 6	
	have received 2	units of NovoLog sliding			monthsat 100% proficiency, th	nen
	scale insulin. No sliding scale insulin was documented as given. On 7/26/14 at 6:00 a.m., a blood glucose				quarterly thereafter for 2	
					consecutive quarters. Issues	
					identified with Diabetes Management, Vital Signs, Wei	aht
					Management, or AIMS	y'''
		rded. As indicated by the			completion by the Quality	
	01 300 was 1600	idea. As maicaled by the				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155072			LDING	NSTRUCTION 00	(X3) DATE COMPL 08/27/	ETED	
	PROVIDER OR SUPPLIER		p. why	STREET A	ADDRESS, CITY, STATE, ZIP CODE LBANY ST GROVE, IN 46107	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	have received 8	er the resident should units of NovoLog sliding o sliding scale insulin as given.			AssuranceCommittee will be addressed via corrective action plan.	on	
	Monitoring Tool indicated Reside	Capillary Blood Glucose for August 2014, nt #70 was not ling scale insulin as					
	of 415 was recorsliding scale order have received 10 sliding scale insu	O a.m., a blood glucose ded. As indicated by the er the resident should units of NovoLog alin. No sliding scale mented as given.					
	of 395 was recorsliding scale order have received 8 to	O a.m., a blood glucose ded. As indicated by the er the resident should units of NovoLog sliding o sliding scale insulin as given.					
	of 255 was recorsliding scale order have received 4	O a.m., a blood glucose ded. As indicated by the er the resident should units of NovoLog sliding o sliding scale insulin as given.					
		00 a.m., a blood glucose ded. As indicated by the					

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SUF	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETI	
		155072	B. WIN	IG		08/27/20	114
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					BANY ST		
BEECH (GROVE MEADOWS	5		BEECH	GROVE, IN 46107		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE C	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	"	er the resident should					
		units of NovoLog					
	sliding scale insulin. No sliding scale						
	insulin was documented as given.						
	1h The clinical	record of Resident #139					
		1 8/20/14 at 2:53 p.m.					
		ded, but were not limited					
	to, diabetes.	ded, but were not infinted					
	Resident #139 had a plan of care dated 2/24/14, indicating the resident was at						
		effects of high or low					
		ated to use of glucose					
	_	ation and/or diagnosis of					
	I -	s. Interventions included,					
		ited to, "blood sugars as					
		lications as ordered."					
	A review of the	recapitulation of					
	physician's order	rs for August 2013,					
	indicated Reside	ent #139 was ordered					
	insulin lispro (H	umalog, a short acting					
	insulin) on a slid	ling scale dose with					
	meals and at bed	ltime with a start date of					
	3/27/14. The sli	ding scale dose was					
	based on the resi	ults of blood glucose					
		onitoring, also ordered to					
	be completed wi	th meals and at bedtime.					
	The sliding scale	e insulin dosage with					
		51 - 200 = 1 units, 201 -					
		51 - 300 = 3 units, 301 -					
	· · · · · · · · · · · · · · · · · · ·	eater than $351 = 5$ units,					
	_	d sugars less than 70 or					
	l	="	- 1			I	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155072		A. BUII	LDING	NSTRUCTION 00	(X3) DATE COMPI 08/27 .	LETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE BANY ST GROVE, IN 46107	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	dosage at bedtim unit, 301 - 400 =	The sliding scale e included 201 - 300 = 1 2 units, greater than 401 Il for blood sugars less r than 401.					
	Monitoring Tool indicated Reside	Capillary Blood Glucose for August 2014, nt #139 was not ling scale insulin as					
	of 279 was recorsliding scale ordehave received 3	O a.m., a blood glucose ded. As indicated by the er the resident should units of Humalog sliding o sliding scale insulin as given.					
	a blood glucose or received 1 unit o	n 8/1/14, the resident had of 186 and should have f sliding scale insulin. insulin was documented					
	blood glucose of received 4 units	0 p.m., the resident had a 348 and should have of sliding scale insulin.					
	blood glucose of	0 p.m., the resident had a 392 and should have of sliding scale insulin.					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155072			LDING	NSTRUCTION 00	(X3) DATE COMPI 08/27			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 ALBANY ST BEECH GROVE, IN 46107					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
		on indicated Resident units of sliding scale						
	a blood glucose received 1 unit of No sliding scale as given. At 9:0 resident had a blushould have received insulin. No was documented On 8/6/14 at 6:00 blood glucose of received 1 unit of No sliding scale as given. The blushould a.m., was	0 a.m., the resident had a 154 and should have f sliding scale insulin. insulin was documented ood glucose for 8/6/14 at documented as 353.						
	of sliding scale i	uld have received 5 units nsulin. The sliding scale mented as 8 units						
	a.m., was docum resident should h sliding scale insu	se for 8/7/14 at 11:00 ented as 497. The nave received 5 units of alin. The sliding scale mented as 8 units						
	_	se for 8/8/14 at 6:00 ented as 321. The						

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155072		LDING	NSTRUCTION 00	(X3) DATE COMPL 08/27/	ETED
	PROVIDER OR SUPPLIER		<u> </u>	2002 AL	ADDRESS, CITY, STATE, ZIP CODE LBANY ST GROVE, IN 46107		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	sliding scale inst	nave received 4 units of ulin. No sliding scale mented as given.					
	a.m., was documentative sliding scale insulin	se for 8/9/14 at 11:00 a.m. se for 8/9/14 at 9:00 mented as 400. The mave received 2 units of ulin. No sliding scale mented as given. se for 8/10/14 at 11:00 mented as 174. The mave received 1 unit of ulin. No sliding scale mented as given. ion lacked a blood					
	_	ulin. No sliding scale imented as given.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155072		MULTIPLE CONS ILDING	STRUCTION 00	(X3) DATE SURVEY COMPLETED 08/27/2014
NAME OF PROVIDER OR SUPPLIER BEECH GROVE MEADOWS	B. WIN	STREET AD	DRESS, CITY, STATE, ZIP CODE BANY ST BROVE, IN 46107	
(X4) ID SUMMARY STATEMENT OF DEFICE PREFIX (EACH DEFICIENCY MUST BE PRECEIT TAG REGULATORY OR LSC IDENTIFYING IN	DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
The blood glucose for 8/13/14 at a.m., was documented as 192. Tresident should have received 1 sliding scale insulin. No sliding insulin was documented as giver. The documentation lacked a blooglucose and sliding scale insulin administration for 8/13/14 at 11: The blood glucose for 8/14/14 at a.m., was documented as 176. Tresident should have received 1 sliding scale insulin. No sliding insulin was documented as giver. The blood glucose for 8/14/14 at p.m., was documented as 347. Tresident should have received 2 sliding scale insulin. The docum indicated the resident received 4 sliding scale insulin. The blood glucose for 8/15/14 at a.m., was documented as 152. Tresident should have received 1 sliding scale insulin. No sliding insulin was documented as giver. The blood glucose for 8/16/14 at a.m., was documented as 158. Tresident should have received 1 sliding scale insulin. No sliding insulin was documented as 158. Tresident should have received 1 sliding scale insulin. No sliding insulin scale insulin. No sliding insulin scale insulin. No sliding scale insulin. No sliding	The unit of scale n. od and another one of the unit of scale n. t 11:00 The unit of scale n. t 9:00 The units of mentation aunits of the unit of scale n. t 6:00 The unit of scale n.			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155072	B. WIN			08/27/	/2014
NAME OF F	ROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					BANY ST		
BEECH (GROVE MEADOWS	3		BEECH	GROVE, IN 46107		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
TAG		LSC IDENTIFYING INFORMATION)		TAG	But tells (C1)		DATE
	msum was doct	imented as given.					
	The blood gluco	se for 8/16/14 at 11:00					
	The blood glucose for 8/16/14 at 11:00 a.m., was documented as 315. The						
	*	nave received 4 units of					
		ulin. No sliding scale					
	_	-					
	msum was doct	imented as given.					
	The blood gluco	se for 8/17/14 at 6:00					
	_	nented as 262. The					
	*	nave received 3 units of					
		ulin. The documentation					
	_	ident was administered 2					
	units of sliding s						
	units of sharing s	scare msum.					
	During an interv	riew with Licensed					
	_	(LPN) #5 on 8/19/14 at					
		#5 indicated the results of					
	_	were documented on the					
		vsheet and then in the					
	•	he blood sugar the					
	amount of slidin	_					
		ould be documented.					
		d the flowsheet was the					
		iding scale insulin					
	administration w	•					
	adiministration w	as documented.					
	2a The clinical	record of Resident #139					
		n 8/20/14 at 2:53 p.m.					
		ded, but were not limited					
	to, diabetes.	ava, out word not ininiou					
	10, 41400105.						
	Resident #139 h	ad a plan of care dated					
		ng the resident was at					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155072	B. WIN	G		08/27/	2014
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF I	KOVIDEK OK SOIT EIEF			2002 AL	BANY ST		
	GROVE MEADOWS				GROVE, IN 46107		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		dvarge effects of high or law		TAG	DEFICIENCY)		DATE
risk for adverse effects of high or low blood sugars related to use of glucose							
	1	•					
	_	ation and/or diagnosis of					
		s. Interventions included,					
		ited to, "blood sugars as					
	· ·	ordered, and medications					
	as ordered."						
	On 3/27/14 Res	ident #139 was ordered					
	-	umalog, a short acting					
	1 \	C, C					
insulin) on a sliding scale dose with meals and at bedtime. The sliding scale							
		on the results of blood					
		ugar) monitoring, also					
		= '					
		mpleted with meals and					
	at bedtime.						
	A review of the	Capillary Blood Glucose					
	Monitoring Tool	l for Resident #139 for					
	the month of Jul	y 2014, indicated the					
	facility failed to	check a blood glucose on					
	7/1/14 at 11:00 a	a.m.; 7/3/14 at 9:00 p.m.;					
	7/7/14 at 11:00 a	a.m.; on 7/8/14 at 11:00					
	a.m., 4:00 p.m.,	and 9:00 p.m.; on					
	7/10/14 at 11:00	a.m.; 7/12/14 at 6:00					
	a.m., 4:00 p.m.,	and 9:00 p.m.; 7/20/14 at					
	11:00 a.m.; 7/22	/14 at 11:00 a.m.;					
	· · · · · · · · · · · · · · · · · · ·	m.; and on 7/31/14 at					
	11:00 a.m. and 9						
	A :. 6.4	Condition Discilled					
		Capillary Blood Glucose					
	_	l for Resident #139 for					
		gust 2014, indicated the					
	facility failed to	check a blood glucose on					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155072		LDING	NSTRUCTION 00	(X3) DATE COMPL 08/27/	ETED
	PROVIDER OR SUPPLIER		B. WIIV	STREET A	DDRESS, CITY, STATE, ZIP CODE BANY ST GROVE, IN 46107	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	8/9/14 at 11:00 a a.m.; and 8/13/14	.m.; 8/11/14 at 11:00 4 at 11:00 a.m.					
	Practical Nurse (2:10 p.m., LPN # the blood sugar flow Glucose Monitor column next to the amount of sliding administered shour LPN #5 indicated only place the glucoumented. During an intervious Nursing (DON) the DON indicated monitoring was resident and the blood sugar monitoring was resident and the blood sugar monitoring was reviewed on Diagnoses included to, diabetes mellitut the body is unab	d the flowsheet was the ucose monitoring was iew with the Director of on 8/21/14 at 3:30 p.m., ed the blood glucose individualized to each expectation was that the itoring would be lered by the physician. record of Resident #26 8/20/14 at 12:55 a.m. ded, but were not limited itus. s is a condition in which le to efficiently move					
	Symptoms of hig	loodstream into cells. gh or low blood sugar blurred vision, feeling					

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			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155072	B. WIN			08/27/	2014
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	£		2002 AL	BANY ST		
	GROVE MEADOWS	8		BEECH	GROVE, IN 46107		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	shaky, dizziness thinking.	weakness, and difficulty,					
uniking.							
	A care plan, date	ed 7/16/14 through					
	10/16/14, indica	ted Resident #26 was,					
	" at risk for fal	ls due toDM [diabetes					
	mellitus]"						
	A care nlan date	d 7/16/14 through					
		ted Resident #26 was at					
		effects of high or low					
		•					
	_	ated to use of glucose					
		ation and/or diagnosis of					
	diabetes mellitus	S.					
	A Progress Note	e, dated 8/5/14 at 9:24					
	a.m., indicated, '	"team met to review					
	assisted fall occu	arring 8/4/14 at 10:48					
] is not diabetic"					
		-					
		event dated 8/4/14,					
		ent #26 was sitting on her					
		athroom floor. This had					
	occurred during	an assisted transfer from					
	her wheelchair to	o the toilet. The fall					
	event indicated t	he resident was not					
	diabetic and an a	accucheck (a finger stick					
		asure blood sugar) was					
	not done.	<i>5)</i>					
	2c. The clinical	record of Resident #67					
		1 8/21/14 at 1:30 p.m.					
		ded, but were not limited					
	to, diabetes mell						
	io, diaoctes illeli	itus and vertigo					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155072			LDING	NSTRUCTION 00	(X3) DATE COMPL 08/27/	ETED	
	ROVIDER OR SUPPLIER		B. WIIV	STREET A	DDRESS, CITY, STATE, ZIP CODE BANY ST GROVE, IN 46107		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	4/12/12 through had the potential sugar reactions. A care plan for R 4/12/12 through was a fall risk. Review of a fall dated 8/10/14, in 10:45 p.m., she was accucheck was not review of a program of the program of t	gress note dated 8/11/14 icated "team met to sed fall occurring 8/9/14					

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PRINTED: 09/26/2014 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		155072	B. WIN			08/27/	2014
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
BEECH (GROVE MEADOWS	;			LBANY ST GROVE, IN 46107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
1710		.mres[ident] was		1710	·		DATE
	_	the floor next to her					
	_	assessment res[ident]					
		VC [wheelchair]"					
	On 8/20/14 at 2:2	20 p.m., the Director of					
		d a policy dated 9/2013,					
	titled, "Fall Mana	agement Program," and					
	indicated the pol	icy was the current					
	policy used by th	e facility. The policy					
	indicated, "A fa	all event will be initiated					
	as soon as the res	sident has been assessed					
	and cared for. The	he report must be					
	completed in full	in order to identify					
	possible root cau	ses of the fall and					
	•	te interventions" One					
	•	on the fall event was					
		ne resident was diabetic					
		ults of an accucheck					
	performed after t	he fall.					
	3a. The clinical r	record of Resident #11					
		8/21/14 at 4:04 p.m.					
		led, but were not limited					
	_	(high blood pressure).					
		· · · · · · · · · · · · · · · · · · ·					
	A review of the r	recapitulation of					
	physician's order	rs for August 2014,					
	indicated Resider	nt #11 was to have vital					
	signs taken daily	and recorded. The					
	origination date of	of the order was 7/29/13.					
	A review of the N	Medication					
		Record (MAR) for June					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	00	(X3) DATE COMPL		
THID I LITTLE	or conduction	155072		LDING		08/27/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00.2	
NAME OF I	PROVIDER OR SUPPLIER				BANY ST		
BEECH (GROVE MEADOWS	3			GROVE, IN 46107		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1	014, indicated the vital re been completed on					
	1 -	to 2:00 p.m.) and should					
		led in "Matrix." The					
	MARs also indic						
		in large letters over and					
	` ′	•					
		to complete the vitals					
	the MARs.	signs were recorded on					
	the WARS.						
	 During an interv	iew with the Director of					
		8/21/14 at 5:35 p.m., the					
	, , ,	he facility did not have a					
		or taking and recording					
	vital signs.	or taking and recording					
	vitai signs.						
	During an interv	iew with the DON on					
	8/22/14 at 11:45	a.m., the DON provided					
	vital signs docur	nented as completed in					
	Matrix 2 times in	1 June 2014, 2 times in					
	July 2014, and n	one for August 2014.					
	The DON indica	ted those were the only					
	results available	for Resident #11.					
	3b. Resident #69	s clinical record was					
	reviewed on 8/20	0/14 at 9:10 a.m.					
	Diagnoses includ	ded, but were not limited					
	to, hypertension	(high blood pressure).					
	Recapulated Phy	vsician orders dated					
	August 2014, inc	dicated, "Take BP [blood					
	pressure] once d	aily in the morning					
	weekly on Tueso	lays and record VS [vital					
	signs] in Matrix	System [electronic					
	charting]." The	recapulated order					

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	OF CORRECTION IDENTIFICATION NUMBER: 155072	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE S COMPLI 08/27/2	ETED
	PROVIDER OR SUPPLIER GROVE MEADOWS	2002 AI	ADDRESS, CITY, STATE, ZIP CODI LBANY ST I GROVE, IN 46107	E	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	indicated the original order date was 8/15/2012.				
	No blood pressures were found in Resident #69's chart documented on the following dates: 11/19/13 2/25/14 4/29/14 5/6/14 5/20/14 6/3/14 6/10/14 6/17/14 6/24/14 7/1/14 7/8/14 7/15/14 7/22/14 8/19/14 On 8/20/14 at 2:10 p.m., the Director of Nursing (DON) indicated they were unable to locate documented blood pressures for the questioned dates. The facility believed the physician had come in around mid May 2014, and discontinued the blood pressures. No order indicating the blood pressures were discontinued was found				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155072	B. WIN	G		08/27/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	ROVIDER OR SOLI LIER			2002 AL	BANY ST	
BEECH (GROVE MEADOWS	3		BEECH	GROVE, IN 46107	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	1	ntation indicating				
Resident #69 refused the blood pressures						
	was found.					
	Cana Dlan initiat	- 4 0/20/11 : 4: 4- 4				
		ed 9/30/11, indicated, ident is at risk for				
		on Approach				
		document:variations				
	in B/P [blood pro	essure]"				
	4 Resident #123	s's clinical record was				
		0/14 at 10:53 a.m.				
		ded, but were not limited				
	•	eart failure (condition				
		s unable to pump enough				
		of the body) and				
	hypertension (hi	gh blood pressure).				
	Physician order	dated 5/21/14, indicated,				
	*	ight] notify IHP [Indiana				
		s] for wt [weight] loss or				
	1	unds] in a day or 5 lbs in				
	a week"	unds] in a day of 5 los in				
	a week					
	Daily weight she	eets indicated a weight				
		nore pounds (lbs) on the				
	following dates:	F (100) on the				
		200 lbs, 10 lb weight loss				
	from 5/28/14	200 100, 10 10 WOISHI 1000				
		94 lbs, 5 lb weight loss				
	from 6/1/14	, · · · · 3				
		00 lbs, 3 lb weight loss				
	from 6/4/14	, 3				
		36 lbs, 4 lb weight loss				

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PRINTED: 09/26/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155072	B. WIN	G		08/27/2014
NAME OF I	PROVIDER OR SUPPLIEF			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	KOVIDEK OK SUPPLIER			2002 AL	BANY ST	
BEECH (GROVE MEADOWS	5		BEECH	GROVE, IN 46107	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	from 6/8/14					
6/10/14 weight 183 lbs, 3 lb weight loss						
	from 6/9/14					
		45 p.m., the Director of				
	Nursing indicate	ed, the facility was unable				
		cumentation indicating				
	the physician wa	as notified of these				
	weight loses.					
5a. The clinical record of Resident #70						
	was reviewed or	n 8/19/14 at 5:15 p.m.				
	Diagnoses inclu	ded, but were not limited				
	to, depressive di	sorder, renal (kidney)				
	failure, liver disc	order, and				
	gastroesophagea	ll reflux (a condition in				
	which the stoma	ch contents leak				
	backwards into t	the tube between the				
	stomach and the	mouth).				
		,				
	A review of the	recapitulation of				
	physician's order	rs for August 2014,				
	1 ^ -	ent #70 was ordered				
		ng (milligrams) (adverse				
	•	apyramidal symptoms				
		ia/uncontrolled or				
		rements) 3 times a day				
	_	an appetite stimulant.				
		date of the metoclopram				
	was 6/8/13.	date of the metoelopiam				
	was 0/0/13.					
	A review of the	Medication				
		Record (MAR) for				
		ndicated Resident #70				
	1145451 2014, 11	idiodica resident II / 0				

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Event ID:

CFVV11 Facility ID: 000029

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE S	ETED	
		155072	B. WIN			08/27/	2014
	PROVIDER OR SUPPLIER			2002 AL	ADDRESS, CITY, STATE, ZIP CODE BANY ST		
BEECH (GROVE MEADOWS	5		BEECH	GROVE, IN 46107		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	was administere daily 3 times a d	d metoclopram (Reglan) ay.					
	Abnormal Involution (AIMS/an assess extrapyramidal strapyramidal strapyr	esident #70 indicated an untary Movement Scale sment to evaluate for symptoms and/or tardive completed 11/5/13. riew with the Director of on 8/22/14 at 10:30 a.m., red the AIMS completed a most recent one for record of Resident #139 at 8/20/14 at 2:53 p.m. ded, but were not limited (a condition that occurs the takes too long to recapitulation of res for August 2014, and #139 was ordered eglan) 10 mg verse reactions: I symptoms tardive introlled or involuntary					
	· · · · · · · · · · · · · · · · · · ·	he origination date of the					

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				nstruction 00	(X3) DATE S COMPLE		
		155072	A. BUI B. WIN	LDING G		08/27/2	
	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE LBANY ST GROVE, IN 46107		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	August 2014, in	Medication Record (MAR) for dicated Resident #139 d metoclopram daily 3					
	During a review of observation reports completed for Resident #139 no Abnormal Involuntary Movement Scale (AIMS/an assessment to evaluate for extrapyramidal symptoms and/or tardive dyskinesia) were found.						
	Nursing (DON)	iew with the Director of on 8/22/14 at 10:30 a.m., ed no AIMS had been esident #139.					
	was reviewed or Diagnoses include to, restless leg sy compulsive diso diabetes, and gas	record of Resident #11 a 8/21/14 at 4:04 p.m. ded, but were not limited yndrome, obsessive rder, anxiety, depression, stroparesis (a condition in the stomach takes too					
	indicated Reside metoclopram (R extrapyramida dyskinesia/unco	recapitulation of rs for August 2014, ent #11 was ordered eglan) (adverse reactions: I symptoms tardive introlled or involuntary mg 4 times a day for					

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Event ID:

CFVV11

Facility ID: 000029

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PRINTED: 09/26/2014 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER BEECH GROVE MEADOWS SIRREIT ADDRESS, CITY, STATE ZIP CODE 2002 ALBAINY ST BEECH GROVE, IN 46107 SECH DEFICINCY MUST BE PRECEDED BY FULL PREFIX TAG GIAbers. A review of the Medication Administration Record (MAR) for August 2014, indicated Resident #11 was administered metoclopram daily 4 times a day. During a review of observation reports completed for Resident #11 no Abnormal Involuntary Movement Scale (AIMS/an assessment to evaluate for extrapyramidal symptoms and/or tardive dyskinesia) were found. During an interview with the Director of Nursing (DON) on 8/21/14 at 3:30 p.m., the DON indicated Resident #11 was receiving Reglan and should have had an AIMS completed, but no AIMS had been completed for Resident #11. The DON provided the "Documentation Guidelines for Nursing" dated 6/2014, and indicated, "Assessments completed - OtherAIMS - every 6 months for residents receiving antipsychotics or Reglan [metoclopram]" The Nursing Drug Handbook, 34th edition, copy right 2014, indicated	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	00	COMPL		
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SAME OF PROVIDER OR SUPPLIES BEECH GROVE MEADOWS				B. WIN		ADDRESS CITY STATE ZIP CODE		
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Reglan [metoclopram]" The Nursing Drug Handbook, 34th edition, copy right 2014, indicated			•					
The Nursing Drug Handbook, 34th edition, copy right 2014, indicated								
edition, copy right 2014, indicated		Tegian Iniciocio	γρτωπ1					
edition, copy right 2014, indicated		The Nursing Dru	ıg Handbook, 34th					
		_	_					
residents receiving metocropram should		residents receivi	ng metoclopram should					

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CFVV11 Facility ID: 000029

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155072	B. WIN	G		08/27/	2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 ALBANY ST BEECH GROVE, IN 46107			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION DATE
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY))	
	be assessed and involuntary mov						
	3.1-35(g)(2)						
F000309 SS=D	must provide the reservices to attain of practicable physic psychosocial well-the comprehensive care. Based on intervithe facility failed services in accordance for a residence evidenced by fail 1500 ml (millilith to observe the dispass). (Resident Findings included 1. The clinical results was reviewed on Diagnoses included to, diabetes and requiring dialysinal A Significant Che (MDS) assessments.	BEING st receive and the facility necessary care and or maintain the highest al, mental, and being, in accordance with e assessment and plan of ew and record review, d to provide the necessary dance with the plan of nt receiving dialysis as lure to restrict fluids to ers) each day and failure alysis site on a daily #139)	F00	0309	1.Fluid intake for resident #1 was immediatelyreviewed and adjusted accordingly. Residen #139's dialysissite was immediately checked by RN a assured within normal limits. 2.All residents on Fluid restriction have thepotential to affected. Fluid intake for all residents with a fluidrestriction was immediately reviewed and adjusted accordingly. The dialysis sites for all residents ondialysis were checked by RI and assured within normal lim 3.Licensed personnel will be in-serviced on theproper calculation of the fluid restriction including the fluids associated medication administration by S Development Coordinator /Designee. Physician will be notifiedadjustments of schedu fluids will be made if necessar	nd be d N its. con with Staff	09/26/2014

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Event ID:

CFVV11

Facility ID: 000029

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPL	ETED
		155072	A. BUII B. WIN			08/27/	2014
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	t			BANY ST		
BEECH (GROVE MEADOWS				GROVE, IN 46107		
					GROVE, IN 40107		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	l `	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	•		DATE
	~	se and received dialysis 3			assure maintenanceat limit.		
	times a week. A	Brief Interview for			Licensed personnel will bein-serviced on post-dialysis		
	Mental Status (E	BIMS) assessed the			protocols including following th	ne.	
	resident as havin	ng mild cognitive			physiciansorders for dialysis s		
		a score of 12. The			assessment by the Staff		
		essed as requiring			Development Coordinator		
		nce of 1 staff person for			/Designee. Fluid restriction		
	eating and person	-			compliance will be reviewed do	aily	
	eating and person	nai nygiene.			by the RegisteredDietitian or designee through intake record	de	
	D :1 . #1201	1 1 0 1 1			and Medication	us	
		ad a plan of care dated			AdministrationRecord. Dialysis	3	
	·	ndicated the resident was			site assessment will be		
	at risk for fluid i	mbalance due to diuretic			completed daily through the		
	medication, assis	stance with food and			DialysisAppointment Assessm		
	fluids, and had a	fluid restriction of 1500			Form by the Director of Nursin	g /	
		is included, but were not			Designee.		
		nter pitcher in room,			4.Results of that daily review will be monitoredby the fluid	′	
	· ·	courage fluids, and fluid			restriction CQI tool reviewed		
	· ·	tary to provide 360 ml			monthly at the Quality		
		80 ml with lunch and			AssuranceCommittee meeting	for	
	· ·				6 consecutive months at 90%		
		ing to provide 180 ml on			proficiency then		
	· ·	gs and 60 ml for night			quarterlythereafter for 2 consecutive quarters. The res	ulto	
	shift for a total o	f 1740 each day.			of those assessments will be	uits	
					monitored by the Dialysis		
	A review of the	recapitulation of			CQImonthly at the Quality		
	physician's order	rs for August 2014,			Assurance Committee meeting		
	indicated the res	ident had a fluid			for 6 consecutive months at 90	%	
	restriction of 150	00 ml per day. The			proficiency then quarterly		
		of the fluid restriction			thereafter for 2 consecutive quarters. Issues identified with	,	
	~	e division of fluids			fluid restrictionand/or following		
					physicians orders for dialysis s		
	indicated the resident had 60 ml for night shift and 180 ml for days and evenings for medication administration. The				assessment will beaddressed		
					the Quality Assurance Commit	ttee	
					via corrective action plan.		
		s for meals indicated the					
	resident was allo	owed 360 ml with					

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AND PLAN OF COR	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155072		BUILDING 00			COMPLETED 08/27/2014	
NAME OF PROVID			2002 AL	DDRESS, CITY, STATE, ZIP CODE BANY ST GROVE, IN 46107			
TAG RI	(EACH DEFICIENC EGULATORY OR L	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE	
supp		ml for lunch and of 1740 ml, 240 ml restriction.					
Adm Aug rece adm fluid fluid fluid fluid fluid fluid fluid fluid Dur Diet the l alwa resti to di requ had the d had A re the d indid weig mon appr cons on ti resid	gust 2014, indicited the fluids inistration and ds for all three ds received within an intervietician (RD) on RD indicated ays compliant riction and the ivide the fluid tested. The R discovered the division for dimade adjustment of the R dialysis center cated the residual gain of 4.4 and the fluid agent 2 learn of August 2 roximately 2 learn per content of the Rounding 1 sumption per content and the residual sumption per content and the residual sumption per content and the residual sumption per content and the Rounding 1 sumption per content and the residual sumption per content and the residua	ecord (MAR) for cated the resident is with medication in direceived additional is shifts as well as the eth meals. Example with the Registered is 8/23/14 at 10:15 a.m., with the fluid is facility had attempted is as the resident had indicated the facility is overage of fluids in etary and nursing and itents to plan of care. Founding Report from it dated 8/13/14, then that an average is kg (kilograms) for the 2014, which indicated					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155072	LDING	NSTRUCTION 00	(X3) DATE COMPL 08/27 /	ETED
	PROVIDER OR SUPPLIER		2002 AL	ADDRESS, CITY, STATE, ZIP CODE BANY ST GROVE, IN 46107	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	a.m., with Licens (LPN) #5 and the indicated the rec 1200 ml restrictinursing nor by dadded to the plan. As of 8/23/14 at was unable to prototal fluid intake the months of Apagust 2014. On 8/20/14 at 5: provided the Fluidated 4/2011, and was the one currous the policy indicated physician's order will be followed divided between Services"	iew on 8/23/14 at 11:00 sed Practical Nurse e RD, LPN #5 and RD ommendation for the on had not been noted by ietary and had not been n of care for the resident. 1:00 p.m., the facility ovide an accurate daily for Resident #139 for oril, May, June, July nor 15 p.m., the DON id Restriction policy d indicated the policy ently used by the facility. ated, "Residents with a r for a fluid restriction by the facility and Dietary and Nursing ecord of Resident #139 18/20/14 at 2:53 p.m.				
	_	led, but were not limited al disease requiring a week,				
	(MDS) assessme assessed Resider	ent completed 6/14/14, at #139 as having end se and received dialysis 3				

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	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	00	(X3) DATE COMPL	
THIND TETHIN	or condition	155072		LDING		08/27/	
		1000.2	B. WIN		ADDRESS CITY STATE TIP CODE	00/21/	2011
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE LBANY ST		
BEECH (GROVE MEADOWS	3			GROVE, IN 46107		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
IAG		Brief Interview for		TAG	DEFICIENCY)		DATE
		SIMS) assessed the					
	`	,					
	resident as havin	-					
	_	a score of 12. The					
		essed as requiring					
		nce of 1 staff person for					
	eating and person	nai nygiene.					
	A review of the	recapitulation of					
		rs for August 2014,					
	1 2	lysis site should be					
	assessed on a da	· -					
	A review of the	MAR for July 2014,					
	indicated the dia	lysis site was observed					
	on Monday, Wed	dnesday and Friday for					
	the month.						
	On 9/20/14 at 5.	15 mm the Dimester of					
		15 p.m., the Director of					
		provided the Dialysis					
		d 9/2012, and indicated					
		ne current one used by the					
		icy indicated, "An					
		e resident's dialysis site d daily to include bruit					
	•	licable), condition of					
		nage, pain, warmth,					
	· ·	orded as the Medication					
	•	Record (MAR) and/or					
		eet specific to facility					
	policy"	or specific to facility					
	poncy						
	3.1-37(a)						
	, ,						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					ì ′	TE SURVEY IPLETED	
		155072	A. BUII B. WIN			08/27/	2014
	PROVIDER OR SUPPLIER		•	2002 AL	ADDRESS, CITY, STATE, ZIP CODE LBANY ST GROVE, IN 46107		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F000315 SS=D	BLADDER Based on the resident sessessment, the foresident who entered indwelling cathete the resident's clinic that catheterization resident who is increceives appropriate to prevent urinary restore as much in possible. Based on interviting failed indications for urobtained for 1 of urinary catheter the bladder) use. Findings includes Resident #59's chreviewed on 8/22 Diagnoses included, urinary retents Resident #59 was facility on 7/22/1 abdominal surges Physician orders "[manufacturer's catheter] catheter	linical record was 2/14 at 10:21 a.m. ded, but were not limited ion. s readmitted to the 14, after having	F00	0315	1.Resident #59 was reviewe by Urologist 9-2-14 todetermin whether catheter use was still indicated in his plan of care. Appropriate associated diagnowas obtainedfor continued use catheter. 2.All residents with catheters have the potentialto be affected. All residents withcatheters will reviewed by physician to assurcontinued use of catheter isindicated in their plan of care. Appropriate associated diagnoses will be ensured for each. 3.Licensed personnel will be in-serviced on theproper use of Catheters and ASC'spolicy and procedure for their use by the Staff Development Coordinato /Designee. DNS / Designee woonductchart review each morning during morning meeting to ensure residents withcathet have been evaluated by the attending physician for continuation.	e sis e of d. be re	09/26/2014

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155072	(X2) MU A. BUII B. WIN	LDING	onstruction 00	(X3) DATE COMPI 08/27	LETED
	PROVIDER OR SUPPLIER		B. WIIW	STREET A	ADDRESS, CITY, STATE, ZIP CODE LBANY ST GROVE, IN 46107	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	N BE RIATE	(X5) COMPLETION DATE
	7/24/14, 8/4/14, Resident #59 had due to urinary remotes did not indor to identify the #59's urinary returned from the urinary returned from the urinary catheter. The physician diremove the catheter and the urinary catheter. The physician diremove the catheter and the urinary catheter. The physician diremove the catheter and the urinary catheter. The physician diremove the urinary catheter. The physician diremove the urinary catheter. The physician diremove the catheter and the urinary catheter. The physician diremove the urinary catheter and the urinary catheter are directly sphysician and 10:45 a.m., an or Resident #59 to if the urinary catheter and the urinary catheter and the urinary catheter and the urinary catheter are not specifically sphysician and the urinary catheter are	ed 7/25/14, indicated, ident requires an ry catheter R/T [related			use. 4.Catheter use will be monitored using theCatheter reviewed monthly at the Quasurance Committee mee for 6consecutive months at proficiency, then quarterly ficonsecutivequarters. Issue identified withCatheter use addressed by the Quality Assurance Committee viacorrective action plan.	ality ting 90% or 2 s	

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	of correction (X1) PROVIDER/SUPPLIER/CLIA (IDENTIFICATION NUMBER: 155072	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 08/27/2014			
	PROVIDER OR SUPPLIER GROVE MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 ALBANY ST BEECH GROVE, IN 46107					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION			
	7/22/14 at 11:32 a.m., indicated, "Urinary retention after removing [manufacturer's name for an urinary catheter] 7/16/14: re-anchored [manufacturer's name for an urinary catheter] - urinary retention 7/19 [2014], can try wo [sig] dc [discontinue] [manufacturer's name for an urinary catheter] after bladder training at ecf [extended care facility] once he is more strong and abdominal wound better." On 8/23/14 at 12:30 p.m., the Director of Nursing indicated, the facility reads discharge notes from the hospital in their inter-disciplinary team (IDT) meetings. She did not recall this statement in Resident #59's discharge note. She continued to indicate, the facility calls the Resident's physician to ask to discontinue a urinary catheter on admission, if there is not a necessary indication for the use of the catheter. An IDT Bladder Continence Review was completed on 8/13/14 at 4:40 p.m., indicated Resident #59 was, " mentally and physically aware of the need to void and able to use a toilet, commode, urinal or bedpan." The review also indicated, Resident #59 was, "mentally and physically able to resist voiding to attempt a bladder retraining program."						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155072		A. BUILDING B. WING	00	COMPLETED 08/27/2014	
	PROVIDER OR SUPPLIER		2002 A	ADDRESS, CITY, STATE, ZIP CODE LBANY ST I GROVE, IN 46107	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	8/14/14, and 8/2	es dated 7/31/14, 8/7/14, 1/14, indicated Resident dominal wound was			
F000322 SS=D	EATING SKILLS Based on the com a resident, the faci (1) A resident who enough alone or w by naso gastric tut clinical condition d naso gastric tube w (2) A resident who gastrostomy tube it treatment and serv pneumonia, diarrh metabolic abnorma	ulcers and to restore, if			
	Based on observer interview, the factorized method were followed during of medications the	ation, record review, and cility failed to ensure s of clinical practice uring the administration arough an enteral tube, ations. (Resident #76)	F000322	1.LPN #3 was in-serviced immediately by the ADNSon to ASC policy for g-tube utilization 2.All residents receiving nutrition via g-tube havethe potential to be affected. All Licensed staff were in-service ADNS onthe ASC policy for g-tube utilization by 9/26/14. 3.All licensed staff will received.	d by

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155072	B. WIN			08/27/	2014
			Б. WII.		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				LBANY ST		
BEECH (GROVE MEADOWS	3			GROVE, IN 46107		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEBLEGENCY)		COMPLETION
TAG		*		TAG	· ·		DATE
TAG	Findings include During an obser 11:55 a.m., Licer (LPN) #1 gave in #76 through an etube surgically in into the stomach inserting a small tube to check for tube in the stomasmall amount into medication ad tube. LPN #3 dibefore she admir through the tube checked to make being digested at the stomach) Du LPN #1 at that tifacility policy we every shift, not emedications. On 8/21/14 at 3:: Nursing(DON) processed to the stomach of the stom	exation on 8/21/14 at msed Practical Nurse medications to Resident enteral tube (a hollow mserted through the skin). LPN #3 was observed amount of air into the each and then instilling a so the tube of water prior ministration through the d not check for residual mistered medication. (Residual should be sure gastric contents are and not just building up in uring an interview with me, she indicated the as to check for residual each time they gave 30 p.m., the Director of provided a policy dated enteral Tube - ministration," and icy was the one currently ity. The policy indicated, and tube for patency &		TAG	in-servicetraining via Skills Validation Checklist for skills related to g-tubemedication administration. All licensedpersonnel will complet an observed G-tube skills validation by DNS or designee verify training. 4.G-tube use will be monitor using the EnteralTherapy CQI, reviewed monthly at the Qualit Assurance Committee meeting for 6consecutive months at 90 proficiency, then quarterly for 2 consecutivequarters. Issues identified with G-tubeuse will b addressed by the Quality Assurance Committee via corrective actionplan.	te to ed y y 3 %	DATE
	_	" At that time, the DON					
		were always supposed to					
	cneck for residua	al prior to administering					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED			
		155072	B. WING		08/27/2014
	PROVIDER OR SUPPLIE		2002 A	ADDRESS, CITY, STATE, ZIP CODE LBANY ST H GROVE, IN 46107	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG		ough an enteral tube.	TAG	Jan Claricity	DATE
	3.1-44(a)(2)				
F000323 SS=E	The facility must environment remains hazards as is possible receives adequate assistance devices. Based on observinterview, the faresident safety fin a soiled utility halls and an eye and C halls, for observations. Traffect 16 cognitic (Residents #69, 32, 99, 106, 118 on the A, B, and cognitively important to the same shades of the s	RVISION/DEVICES ensure that the resident ains as free of accident sible; and each resident e supervision and es to prevent accidents. vation, record review, and ecility failed to ensure from hazardous chemicals by room on the E and F wash station on the A, B, 1 of 1 random his had the potential to fively impaired residents 22, 65, 110, 139, 104, 87, 1, 2, 126, 155, 108 and 1) 1 C halls, and 3 faired residents (Residents 3) on the E and F halls. e: dom observation on p.m. on the A, B, and C to the soiled utility room unlocked. The following	F000323	1.All doors leading to areas potentialhazards were immediately locked upon discovery. 2.All residents have the potential to beaffected. All do leading to areaswith potential hazards were checked and immediately locked upon discovery. 3.The locking mechanism of doors leading to areas with potential hazards were modified to prevent deactivating thenumerical keypad release. closuremechanisms were calibrated to assure appropriate automatic closure and latching doors. Proper locking doors where the body to be be body to be a considered of the point	ors n all ed All te gof vill al y the

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLE	ETED
		155072	B. WIN			08/27/2	2014
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				BANY ST		
BEECH C	GROVE MEADOWS				GROVE, IN 46107		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG			DATE
TAG	Two 1 gallon bor Disinfectant. The indicated to call ingested. If inha air. If person no ambulance or give Two 1 gallon bor Cleaner. The lab and skin irritation. The above bottle approximately 5. A bucket, sitting with approximate unknown liquid in the soiled utility used by all 3 half 2. During a rande eye wash station 8/17/14 at 6:55 pt to be unlocked, were observed in Approximately 2.	ttles of Neutral Quat e label on the bottles poison control if led, get person to fresh t breathing, call 911 or we artificial respiration. ttles of Neutral Floor bel indicated, causes eye n. s were on a shelf 1/2 feet high. on the floor of the room, ely 1/2 gallon of in it. y room was located and ls. (A, B, C) om observation of the on the E and F halls on o.m., the door was found The following items of the room:		TAG	reviewed monthly at QualityAssurance Committee meeting for 6 consecutive mor at 100% proficiency, thenquart for 2 consecutive quarters. Iss identified related to security of potentially hazardous materialswill be addressed by Quality Assurance Committee corrective actionplan.	oths erly ues	DATE
	_	tle of Neutral Quat e label on the bottles					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155072	B. WIN	IG		08/27/	2014
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					BANY ST		
BEECH (GROVE MEADOWS	3		BEECH	GROVE, IN 46107		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	indicated to call	poison control if					
	ingested. If inha	lled, get person to fresh					
	air. If person no	t breathing, call 911 or					
	ambulance or giv	ve artificial respiration.					
	A one gallon bot	tle of Neutral Floor					
		el indicated, causes eye					
	and skin irritatio						
	A one gallon bot	tle of Carpet Extraction					
		bels on the bottles					
		ger corrosive to eyes,					
	_	tion. Harmful or fatal if					
	swallowed."	ttion. Hallillul of fatal fi					
	swanowed.						
	Tryo 1 quart hatt	eles of Glass Plastic					
		pels on the bottles					
	indicated, "Caus	es eye irritation."					
	A 1						
		red, trash can filled with					
	trash tied in clea	r plastic bags.					
		15 1 1 54					
	* *	was discolored, with a					
	" '	g around the middle and					
	_	oughout, dripping water					
	from corroded fa	nucet.					
	This eye wash st	ation was located and					
	used by both E a	nd F halls.					
	On 8/17/14 at 7:	00 p.m., Licensed					
	Practical Nurse #	‡3 indicated the doors					
	were supposed to	be locked. At that					
		e door to the eye wash					
	-, ,	J					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155072		LDING	onstruction 00	(X3) DATE COMPL 08/27/	ETED	
	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE LBANY ST GROVE, IN 46107	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	"catch." He were tried the door from the inside. up and indicated the hallway and enter the room. The Maintenance at that time and to utility room was On 8/17/14 at 7: Nursing indicated unlocked from the hallway Documentation to Manager of the Anidicated there were independent of the most recent Set assessments residents were continued to the E and F halls mobile. The most Minimum Data St.	10 p.m., the Director of d both doors had been he inside, and both doors had been he inside, and both doors had locked and opened of only after using a code. The eceived from the Unit A, B, and C halls, were 36 residents who had the mobile on the unit. It facility Minimum Data indicated 16 of those 36 regnitively impaired. The eceived from the he ing on 8/22/14 at 10:25 here were 13 residents on a who were independently				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155072		A. BUILDING B. WING O0 COMPLETED 08/27/2014			
	PROVIDER OR SUPPLIER		2002 A	ADDRESS, CITY, STATE, ZIP CODE ALBANY ST H GROVE, IN 46107	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	impaired. 3.1-45(a)(1)				
F000329 SS=D	from unnecessary drug is any drug we dose (including du excessive duration monitoring; or with for its use; or in the consequences which should be reduced combinations of the Based on a comprise resident, the facility residents who have drugs are not give antipsychotic drug treat a specific condocumented in the residents who use receive gradual do behavioral intervel contraindicated, in these drugs.	DRUGS ug regimen must be free drugs. An unnecessary then used in excessive plicate therapy); or for a; or without adequate out adequate indications the presence of adverse tich indicate the dose d or discontinued; or any the reasons above. The reasons above assessment of a ty must ensure that the not used antipsychotic the these drugs unless therapy is necessary to the dition as diagnosed and the clinical record; and the antipsychotic drugs the reductions, and the province of the record of the reductions, and the province of the record of the reductions, and the province of the record of the reductions, and the province of the reduction of th			
	the failed to ensure was completed for movements for 3 for unnecessary in	ew and record review, are adequate monitoring or abnormal involuntary of 5 residents reviewed medications. (Resident 39, and Resident #11)	F000329	1.AIMS were completed for residents #70, #139, and #11 a any negative results were communicated to the attendin physician. 2.All residents have the potential to be affected by this	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			00	COMPL	ETED
		155072		LDING		08/27/	
		1.33.2	B. WIN			1 33,21	· ·
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
					LBANY ST		
BEECH (GROVE MEADOW	S		BEECH	I GROVE, IN 46107		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					practice. All residents		
	Findings include	e:			takingMetoclopram were		
					reviewed for completed		
	1 The distinct	and of Davidant #70			AIMS. AIMS were completed		
	1. The clinical record of Resident #70				all residents on Metoclopram	that	
		n 8/19/14 at 5:15 p.m.			lacked them.	idad	
	Diagnoses inclu	ded, but were not limited			3.Licensed staff will be prov in-servicetraining by the Staff		
	to, depressive d	isorder, renal (kidney)			Development Coordinator		
	failure, liver dis	• • • • • • • • • • • • • • • • • • • •			regarding the need for AIMS	onall	
	· ·	al reflux (a condition in			residents taking Metoclopram		
		•			(Reglan), and Compazine, just		
	which the stomach contents leak				they wouldany anti-psychotic		
	backwards into the tube between the				medication by 9/26/14. All ne	W	
	stomach and the	e mouth).			orders will be reviewed daily	at	
					Morning Meeting for among		
	A review of the	recapitulation of			otherthings, required AIMs. [ONS	
		ers for August 2014,			/ Designeewill assure that		
	1 * *	ent #70 was ordered			receiving ant-psychoticmedic		
					will have an AIMS completed		
	_	mg (milligrams) (adverse			every 6 months with abnormatic results reported to the attendition of the strength of the stre		
		apyramidal symptoms			Physician.	i ig	
	tardive dyskines	sia/uncontrolled or			4.Completion of AIMS for		
	involuntary mov	vements) 3 times a day			appropriate medicationsinclu	ding	
	before meals as	an appetite stimulant.			Metoclopram and Compazine	•	
		date of the metoclopram			be monitored by		
	was 6/8/13.	and of the metoeropium			PsychoactiveManagement C		
	was 0/0/13.				tool monthly at Quality Assura	ance	
					Committee meeting for 6		
	A review of the				monthsat 100% proficiency, t	nen	
	Administration	Record (MAR) for			quarterly thereafter for 2		
	August 2014, ii	ndicated Resident #70			consecutive quarters. Issues identified by the Quality	•	
	was administere	ed metoclopram (Reglan)			AssuranceCommittee will		
	daily 3 times a c				addressed by corrective action	n	
					plan.		
	A				['		
	A review of obs	•					
	_	Resident #70 indicated an					
	Abnormal Invol	untary Movement Scale					
	(AIMS/an asses	sment to evaluate for					

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155072			LDING	NSTRUCTION 00	(X3) DATE COMPI 08/27	ETED	
	PROVIDER OR SUPPLIER		p. wiii	STREET A	DDRESS, CITY, STATE, ZIP CODE BANY ST GROVE, IN 46107	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E RIATE	(X5) COMPLETION DATE
	1 2	ymptoms and/or tardive completed 11/5/13.					
	Nursing (DON) the DON indicat	iew with the Director of on 8/22/14 at 10:30 a.m., ed the AIMS completed most recent one for					
	was reviewed on Diagnoses include to gastroparesis	ecord of Resident #139 8/20/14 at 2:53 p.m. ded, but were not limited (a condition that occurs the takes too long to					
	indicated Reside metoclopram (Ro (milligrams) (ad- extrapyramidal dyskinesia/uncon movements) 3 tin	rs for August 2014, nt #139 was ordered eglan) 10 mg verse reactions: I symptoms tardive ntrolled or involuntary mes a day for he origination date of the					
	August 2014, in was administered times a day.	Record (MAR) for dicated Resident #139 d metoclopram daily 3					
	During a review	of observation reports					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155072		LDING	onstruction 00	(X3) DATE COMPL 08/27	ETED	
	PROVIDER OR SUPPLIER		2002 AL	ADDRESS, CITY, STATE, ZIP CODE LBANY ST GROVE, IN 46107		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
	(AIMS/an assess	untary Movement Scale sment to evaluate for symptoms and/or tardive				
	Nursing (DON)	iew with the Director of on 8/22/14 at 10:30 a.m., ed no AIMS had been esident #139.				
	was reviewed on Diagnoses include to, restless leg sy compulsive disordiabetes, and gas	ecord of Resident #11 8/21/14 at 4:04 p.m. ded, but were not limited yndrome, obsessive rder, anxiety, depression, stroparesis (a condition a the stomach takes too				
	indicated Reside metoclopram (R extrapyramida dyskinesia/uncoi	recapitulation of rs for August 2014, nt #11 was ordered eglan) (adverse reactions: I symptoms tardive ntrolled or involuntary mg 4 times a day for				
	August 2014, in	Medication Record (MAR) for dicated Resident #11 d metoclopram daily 4				

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	OF CORRECTION IDENTIFICATION NUMBER: 155072	(X2) MULTIPLE CO A. BUILDING B. WING	00	08/27	SURVEY LETED 7/2014	
	PROVIDER OR SUPPLIER GROVE MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 ALBANY ST BEECH GROVE, IN 46107				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
	During a review of observation reports completed for Resident #11 no Abnormal Involuntary Movement Scale (AIMS/an assessment to evaluate for extrapyramidal symptoms and/or tardive dyskinesia) were found. During an interview with the Director of Nursing (DON) on 8/21/14 at 3:30 p.m., the DON indicated Resident #11 was receiving Reglan and should have had an AIMS completed, but no AIMS had been completed for Resident #11. The DON provided the "Documentation Guidelines for Nursing" dated 6/2014, and indicated the policy was the one currently used by the facility. The policy indicated, "Assessments completed - OtherAIMS - every 6 months for residents receiving antipsychotics or Reglan [metoclopram]" The Nursing Drug Handbook, 34th edition, copy right 2014, indicated residents receiving metoclopram should be assessed and monitored for involuntary movements. 3.1-48(a)(4)					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155072		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 08/27/2014			
	ROVIDER OR SUPPLIER		2002 A	ADDRESS, CITY, STATE, ZIP CODE LBANY ST H GROVE, IN 46107	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
R000000		ntial finding is cited in 410 IAC 16.2-5.	R000000		
R000349	on each resident. maintained under employee of the fa responsibility. The follows: (1) Complete. (2) Accurately doc (3) Readily access (4) Systematically Based on intervi- the facility failed were complete a residents' charts saturations and d not documented #6) Findings include Resident #6's clir reviewed on 8/25	Noncompliance st maintain clinical records These records must be the supervision of an acility designated with that e records must be as sumented. Sible. organized. ew and record review, at to ensure resident charts and accurate for 1 of 7 reviewed in that oxygen lialysis site checks were completely. (Resident	R000349	1.Resident #6 O2 saturation were obtained byDNS. Resid #6 dialysis site waschecked prorder by DNS. 2.All AL residents have the potential to beaffected by this practice. Residentswith order for Oxygen had the O2 saturations checked by the DN Residents receiving dialysis had their siteschecked by DNS perphysicians orders. 3.Staff received in-service training by the StaffDevelopme Coordinator / Designee regard obtaining and documenting	ent er sylvania sylva

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	ILDING	00	COMPLETED
		155072	B. WIN			08/27/2014
NAME OF E	PROVIDER OR SUPPLIER	<u> </u>	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	-
					_BANY ST	
	GROVE MEADOWS	3		<u> </u>	GROVE, IN 46107	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG		DATE
		uctive pulmonary			O2saturations per physicians orders. Staffreceived in-service	ne l
	, ,	seases that block airflow			training by the Staff Developm	
	_	make it hard to breath)			Coordinator / Designee	
		l failure (inability of the			onpost-dialysis protocols	
	*	te body wastes) with			including following the physicial orders for dialysissite assessn	
		l process to remove			and proper documentation.	nont.
		body when the kidneys			4.Vital sign monitoring include	
	are unable to).				properdocumentation with the	
					MAR will be monitored via aud	dits
1. Recapulated Physician orders dated					of the MAR by the DNS /Designee. The results of those	se
August 2014, indicated, "Check O2					auditswill be compiled and	
	[oxygen] Sats [le	evel of oxygen in the			reported to the Quality Assura	nce
	body] every shif	t." The recapulated order			Committee for 6	
	indicated, oxyge	n saturation order was			consecutivemonths with 95% proficiency and quarterly	
	originally ordere	ed on 4/21/14.			thereafter for 2	
					consecutivemenths. Dialysis	site
	Recapulated Phy	sician orders dated			monitoring will becompleted vi	
	August 2014, inc	dicated, "O2 [oxygen] @			Dialysis Appointment Assessn	
	[at] 21 [liters] via	nasal cannula for			form daily by the DNS /Design Results of those forms will	iee.
	nocturnal use for	Sats <90% [less than]."			becompiled and recorded on t	he
	The recapulated	order indicated, oxygen			Dialysis Care CQI monthly for	
	at 2L order was	originally ordered on			review by theQuality Assurance	ce
	4/21/14.				Committee for 6 consecutive	
					months with 90% proficiency thenquarterly thereafter for 2	
	No documentation	on of oxygen saturations			consecutive quarters. Issues	
		were found for April			identified by the committee wil	II
		, nor the following shifts			beaddressed via Corrective	
	in July 2014:	· ·			Action Plan.	
	7/4/14 night shif	t				
	7/13/14 day shift					
	7/14/14 night shi					
	7/15/14 night shi					
	7/21/14 night shi					
	7/22/14 night shi					
	,,,22,11,1115111,3111					

STATEMENT OF DEFICIENCIES				2) MULTIPLE CONSTRUCTION			SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING		00	COMPLETED 08/27/2014		
		155072	B. WIN			06/27	2014	
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE			
DEEOU			2002 ALBANY ST					
BEECH GROVE MEADOWS				BEECH	GROVE, IN 46107			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	CROSS-REFERENCED TO THE APPROP		COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE	
	7/22/14 day shift							
	7/24/14 day shift							
	7/25/14 night shift							
	7/26/14 night shift							
	7/27/14 night shift							
	7/28/14 day shift							
	7/29/14 night shift							
	7/29/14 day shift							
	7/30/14 day shift							
	-							
	On 8/25/14 at 3:25 p.m., the Director of							
	Nursing (DON) indicated, the facility							
	was unable to locate oxygen saturations							
	for April 2014, May 2014, nor the dates							
	in question for July 2014.							
	in question for July 2014.							
	On 8/25/14 at 3:25 n m, the DON							
	On 8/25/14 at 3:25 p.m., the DON							
	provided the Oxygen Therapy policy,							
	dated 4/2014, and indicated the policy							
	was the one currently used by the facility.							
	The policy indicated, " 3. The nurse							
	will coordinate the oxygen therapy							
	services as ordered by the resident's							
	physician"							
	2. Recapulated physician orders dated							
	August 2014, indicated, "Access site							
	[area on the body used to implement							
dialysis] top left forearm, check dressing								
	site daily." The recapulated orders							
indicated the original order date was								
6/4/13.								
	No documentation	on was found indicating						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155072	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 08/27/2014				
	PROVIDER OR SUPPLIE GROVE MEADOW		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 ALBANY ST BEECH GROVE, IN 46107						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETION				
	Resident #6's dialysis site was checked daily for the following months: February 2014 March 2014 April 2014 May 2014 June 2014 July 2014 On 8/25/14 at 3:25 p.m., the DON indicated, The facility was unable to find documentation to indicated Resident #6's dialysis site was checked daily. The DON further indicated the residential facility did not have a policy to refer to for dialysis care.								

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